Revision: HCFA-PM-91-10 (MB)
DECEMBER, 1991

State/Territory: Nebraska

Citation
42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and
1902(d) of the
Act, P.L. 99-509
(Section 9431)

4.14 Utilization/Quality Control

(a) A Statewide program of surveillance and utilization control has implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

X Directly

___ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO –

(1) Meets the requirements of S434.6(a);
(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
(3) Identifies the services and providers subject to PRO review;
(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1902(a)(30)(c) and 1902(d) of the Act, P.L. 99-509 (section 9431)

X By undertaking quality and utilization reviews through contracts with utilization review organizations which do peer reviews (PRO-like/non-PRO-like entities). One contract includes hospital services (selected in-patient and selected out-patient services); the other contract includes mental health substance abuse inpatient services.

X A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation.

Citation	4.14	Utilization/Quality Control (Continued)
42 CFR 438.356(e)	(f)	For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.
42 CFR 438.354 42 CFR 438.356(b) and (d)		The State must ensure that an External Quality Review Organization and its subcontractors Performing the External Quality Review or External Quality Review-related activities meets The competence and independence requirements.

___ Not applicable.

Revision: HCFA AT-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987 4.30 Continued

State/Territory: Nebraska

Citation

(b) The Medicaid agency meets the requirements of –

1902(p) of the Act P.L. 100-93 (secs. 7)

(1) Section 1902(p) of the Act by excluding from participation -

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under Title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

42 CFR 438.808

(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that Is described in section 1128(b)(8)(B) of the Act.

1932(d)(1) 42 CFR 438.610

(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c).

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: Nebraska

Citation
42 CFR 431.51
AT-78-90
46 FR 48524
48 FR 23212
1902(a)(23)
P.L. 100-93
(section 8(f))
P.L. 100-203
(Section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual –

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

Section 1902(a)(23)
Of the Social
Security Act
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid Services, or

Section 1932(a)(1)
Section 1905(t)

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Nebraska

Citation		
42 CFR 431.12(b) AT-78-90	1.4	State Medical Care Advisory Committee There is an advisory committee to the Medicaid agency director on health and medical care services Established in accordance with and meeting all the Requirements of 42 CFR 431.12.
42 CFR 438.104		X The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

State: Nebraska

Citation	Sanctions for MCOs and PCCMs
1932(e) 42 CFR 428.726	(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the Provisions in 42 CFR 438 Subpart I, in manner Specified below:

Intermediate Sanctions. The State may impose Intermediate Sanctions when the MCO acts or fails to act as follows:

A. Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to a client covered under the contract.
B. Imposes on clients premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
C. Acts to discriminate among clients on the basis of their health status or need for health care services.
D. Misrepresents or falsifies information that it furnishes to CMS or to the State.
E. Misrepresents or falsifies information that it furnishes to a client, potential client, or health care provider.
F. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
G. Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
H. Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.
I. Has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Social Security Act and any implementing regulations.

Intermediate Sanctions: Types. The State may impose the following types of intermediate sanctions:

A. Civil monetary ,penalties in the following specified amounts:

State: Nebraska

1. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to clients, potential clients or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
2. A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.
3. A maximum of $15,000 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).
4. A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program.

The State must deduct from the penalty the amount of overcharge and return it to the affected clients(s).

- Appointment of temporary management for the MCO as provided in 42 CFR 438.706.
- Granting clients the right to terminate enrollment without cause and notifying the affected clients of their right to disenroll.
- Suspension of all new enrollment, including default enrollment, after the effective date of the sanction.
- Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- Additional sanctions allowed under state statute or regulation that address areas of noncompliance.

(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

Special Rules for Temporary Management. Temporary management only be imposed by the State if it finds that:

State: Nebraska

A. There is continued egregious behavior by the MCO, including, but not limited to behavior that is described in 42 CFR §438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or

B. There is substantial risk to clients' health; or

C. The sanction is necessary to ensure the health of the MCO's clients while improvements are made to remedy violations under 42 CFR §438.700 or until there is an orderly termination or reorganization of the MCO.

(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

___ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

LIST OF ATTACHMENTS

No.	Title of Attachments
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
	* Supplement 1 - Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
	* Supplement 2 - Definitions of Blindness and Disability (Territories only)
	* Supplement 3 - Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (States only)
	* Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
	* Supplement 2 - Resource Levels – Categorically Needy, Including Groups with Income Up to a Percentage of the Federal Poverty Level, Medically Needy, and Other Optional Groups
	* Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

No.	Title of Attachment
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy
	* Supplement 1 - Case Management Services Supplement 2 - Alternative Health Care Plans for Families Covered Under Section 1925 of the Act
*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups
3.1-C	Standards and Methods of Assuring High Quality Care
3.1-D	Methods of Providing Transportation
*3.1-E	Standards for the Coverage of Organ Transplant Procedures
3.1-F	Definition of MCO, PCCM
4.11-A	Standards for Institutions
4.14-A	Single Utilization Review Methods for Intermediate Care Facilities
4.14-B	Multiple Utilization Review Methods for Intermediate Care Facilities
4.16-A	Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees
4.17-A	Determining that an Institutionalized Individual Cannot Be Discharged and Returned Home
*4.18-A	Charges Imposed on Categorically Needy
*4.18-B	Medically Needy – Premium
*4.18-C	Charges Imposed on Medically Needy and Other Optional Groups
*4.18-D	Premiums Imposed on Low Income Pregnant Women and Infants
*4.18-E	Premiums Imposed on Qualified Disabled and Working Individuals
4.19-A	Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

*Forms Provided

TN NO. MS-03-12

Supersedes Approval Date November 6, 2003 Effective Date August 13, 2003

TN NO. MS-91-24

Nebraska (03-12) Approved: 11/6/03

State/Territory: Nebraska

STATE PLAN UNDER, TITLE XIX OF THE SOCIAL SECURITY ACT
State: Nebraska

Effective: 08/13/03

Nebraska Health Connection (NHC)
MCO and PCCM programs

Citation: Section 1932 of the Social Security Act

A. General Description of the Program

1. This program is called Nebraska Health Connection (NHC). All Medicaid beneficiaries as described in Section C are required to enroll in either a managed care organization (MCO), also known as a health maintenance organization (MCO), or a primary care case management (PCCM) program. Those described In Section D are not subject to mandatory enrollment.

2. The objectives of this program are to reduce costs, reduce inappropriate utilization, and ensure adequate access to care for Medicaid recipients.

3. This program Is Intended to enroll Medicaid recipients in an MCO or PCCM, which will provide or authorize all primary care services and all necessary specialty services, where the assigned medical practitioner will authorize all primary care services and all necessary specialty services. The MCO/PCCM assigned practitioner will act as the Primary Care Physician (PCP). The PCP is responsible for monitoring the care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under this program.

4. The PCP will assist the participant in gaining access to the health care system and will monitor the participant's condition, health care needs, and service delivery on an ongoing basis. The PCP will be responsible for locating, coordinating, and monitoring all primary care and other covered medical and rehabilitation services on behalf of recipients enrolled in the program.

5. Recipients enrolled under this program will be restricted to receive covered services from the PCP or upon referral and authorization of the PCP. The PCP will manage the recipient's health care delivery. The NHC program is intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery. This is accomplished by providing the recipient with a choice between at least two PCCM programs or a combination of one MCO and the PCCM program. Recipients will have a minimum of 45 days to make the selection but may change the initial selection at any time. Pregnant woman may only change plans within the first 90 days of enrollment or identification of their pregnancy if already enrolled (which ever is the latter) or upon good cause for the duration of the pregnancy plus 60 days. The enrollment broker facilitates this through enrollment counseling and information distribution so recipients may make an informed decision. (See Section E for more details.)